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# Summary Technical Report: Stage 2 of a mixed methods study to investigate the acceptability of temporarily suspending visiting to hospitals and care homes during norovirus outbreaks

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# Summary Technical Report:

# Stage 2 of a mixed methods study to investigate the acceptability of temporarily suspending visiting to hospitals and care homes during norovirus outbreaks.

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**Background:**

This technical reports Stage 2 of a mixed methods study to investigate the acceptability of temporarily suspending visiting (TSV) during norovirus outbreaks, from the perspective of patients, visitors and the wider public in Scotland, in order to inform policy development.

Firstly, we conducted a national survey of all NHS Boards and a sample of the Independent Care Home (ICH) sector. We found that TSV practice varied considerably across the NHS in Scotland, with inconsistent availability and use of criteria or policy to guide clinical staff in making TSV decisions; in some places there was a clear policy in place and TSV was routinely implemented; in others there was a policy not to use TSV at all and to advise visitors of the risks instead. In the ICH, TSV practice was much more consistent, with the majority of care homes having a clear policy and implementing TSV for all suspected norovirus outbreaks.

Secondly, we held a series of discussion groups with service users and clinical staff from both the NHS and ICH sector in three different geographical areas, reflecting a large urban city area, a rural area, and a remote area. We asked these groups to identify factors which would make TSV more, or less, acceptable; it is this second stage which is the focus of this technical report.

Finally, we used the findings from the group discussions to develop a survey tool which was distributed to current patients and visitors and posted to a random sample of the general public in the same three geographical areas as before. We received responses from 552 individuals.

**Research questions:**

What factors do i) service users ii) staff suggest might make TSV during norovirus outbreaks more or less acceptable?

| **Objective** | **Data collection methods** |
|---|---|
| To identify and seek consensus around situational and contextual factors which would make TSV during norovirus outbreaks more or less acceptable. | Nominal group discussions with service users and clinical staff in 3 geographically diverse areas (urban, rural, remote); 6 groups in total.<br>Modified on-line Delphi survey (Appendix 3) of ICH managers (n=7) |

**Sample and recruitment:**

Infection Prevention & Control Leads in seven NHS Scotland Boards expressed interest in participating in Stage 2 of the study. Recent norovirus outbreak figures for each volunteering Board were reviewed and case-sites from 3 geographical areas (urban, rural, remote) with recent experience of outbreaks were recruited. Nominated link collaborators within the NHS case-sites supported local arrangements for recruitment of clinical staff and service users.

Separate group discussions were held with nursing staff in the three NHS case-sites and service users in two NHS case sites (we were unable to recruit service-users from the urban area). One ICH volunteered to recruit visitors and seven ICH managers recruited via Scottish Care took part in modified on-line Delphi survey, due to the extended geographical spread of the volunteers.

**Data Collection: Situational factors which make TSV more or less acceptable.**

The following questions were put to each participating discussion group;

- *When do you think stopping visiting might be acceptable during norovirus outbreaks?*
- *When might stopping visiting NOT be acceptable?*
- *What do you think the benefits of stopping visiting during norovirus outbreaks might be?*
- *What do you think the problems/disadvantages of stopping visiting during norovirus outbreaks might be?*
- *What suggestions can you offer to make stopping visiting more acceptable to patients and visitors?*

Standard Nominal Group Technique (see appendix) and scoring of modified Delphi responses was applied to determine the rank order of importance of factors identified by group participants and a comparison of key similarities and differences across service user and staff groups was made according to these ranks. The following tables present the combined top ranking responses for each question (Tables 1-6).

**Table 1: When do you think stopping visiting might be acceptable?**

| **Service users** | **Staff** |
|---|---|
| • When an outbreak of norovirus has been identified | • when outbreak is confirmed |
| • When there is perceived risk to patients, visitors or staff | • professional judgement should be used i.e. following discussion with and risk assessment by IPC team or |

| | |
|---|---|
| | Public Health advisors |
| • To prevent spread within the care environment or back to the community | • generally not acceptable to stop visiting |

**Table 2: When do you think stopping visiting might NOT be acceptable?**

| **Service users** | **Staff** |
|---|---|
| • When patient/resident is terminally ill | • End of life/palliative care |
| • When patient/resident is likely to become very distressed or is particularly dependent on family support e.g. dementia, learning disability, mental health difficulties, children | • seriously ill patients |
| • when a visitor has travelled a long distance | • specific patient groups who may be more dependent on visitors |
| • No exceptions should be permitted | • at the insistence of relatives |
| | • visitor had travelled a long distance |

**Table 3: What do you think the benefits of stopping visiting might be?**

| **Service users** | **Staff** |
|---|---|
| • To contain the spread of norovirus within the care environment / re-establish normal visiting as soon as possible | • reduction in risk of spread within hospital or care home / reducing the length of the outbreak and closure times |
| • To reduce the spread of norovirus back to the community | • reduction in risk of further cross infection/cross contamination into the community |
| • To allow staff to concentrate on looking after residents/patients | • protection of dignity for patients using the toilet or being sick |
| • Maintain dignity patients who may be sick / have diarrhoea | • helping staff resources during shortage of staff |

**Table 4: What do you think the problems or disadvantages of stopping visiting might be?**

| Service users | Staff |
|---|---|
| • Adverse emotional impact on residents/patients; stress, anxiety, low morale, boredom, which was perceived to possibly delay recovery | • Emotional impact on patients; feeling isolated, low mood, anxiety, low morale |
| • Adverse emotional impact on relatives; stress, anxiety | • Staff having to deal with visitor concerns ranging from anxiety to aggression and complaints |
| • Impact on 'care' or services normally delivered by visitors e.g. support, access to laundry, books, food. | • the lack of supplies to patients from home |
| • visitors had travelled a distance | • Increase in staff workload often during increased staff sickness e.g. replacing other therapists, increased telephone calls and time taken to notify next of kin, unable to discharge patients back to care homes |
| • Anger and annoyance/challenging behaviour (from patients and/or visitors) | • care home staff group identified resident rights issues; |

**Table 5: What suggestions can you offer that might make stopping visiting more acceptable?**

| Service users | Staff |
|---|---|
| • Pre-emptive media campaigns before the start of the norovirus season to educate public about preventative measures | • consistent national messages and information campaigns, using the press to promote the benefits of TSV in both hospital & care home settings |
| • Good communication strategy to notify key contacts early | • regular communication and updates for visitors |
| • Media announcements of suspended visiting to give other visitors warning (particularly in remote and rural areas) | • Education/ Written information for patients and visitors |
| • Provision of alternative means of communication between residents/patients and visitors e.g. | • different forms of communication for patients such as access to Skype or ward telephones. |

**Table 6: Recommendations to improve acceptability:**

| The following recommendations gained support during Stage 2 discussions: |
|---|
| • consistent national messages and media campaigns before the start of the norovirus season to educate public about preventative measures |
| • Good communication strategy to notify key contacts early |
| • Media announcements of suspended visiting to give other visitors warning (particularly in remote and rural areas) |
| • Provision of alternative means of communication between residents/patients and visitors e.g. ward telephone (free), skype, facetime |
| • relatives should phone staff for regular updates |
| • staff should provide regular updates to key contacts |

## Summary of findings:

Views expressed by service users and clinicians in Stage 2 were remarkably consistent in relation to the factors that would make TSV more, or less, acceptable, with only occasional differences related to specific situations or contexts. Both service users and staff indicated that TSV was acceptable to reduce spread of the virus, maintain the dignity of patients who may be vomiting or have diarrhoea, and allow staff to focus resources on dealing with patients' needs. Commonly identified exceptional cases were highlighted (e.g. when the patient was terminally ill or a visitor had travelled a long distance) as was the potential challenge for staff of having to deal with patient and visitor complaints. Most notably, only staff groups expressed the view that generally TSV was not acceptable and may contravene patients' and visitors' rights to visit; conversely, some service user groups supported the view that TSV should be routinely applied with no exceptions permitted. Only NHS staff groups highlighted additional workload issues for nurses during TSV e.g. nurses replacing therapists duties, dealing with increased telephone calls.

Both staff and service users expressed the view that greater information to raise awareness of norovirus would be helpful e.g. via national media campaigns.

The factors identified during Stage 2 were then considered in light of theoretical constructs drawn from the Health Belief Model and categorised to inform the development of a survey tool for Stage 3 of the study.

**Appendix: Nominal Group Technique instructions**

The Nominal Group Technique is a method of generating ideas, recording ideas, discussing ideas and voting on ideas. The nominal group is a structured group that meets to gather information about a specific concern. Each discussion is likely to take around one hour.

Two people will serve as group leaders, sharing the responsibilities, one working as a facilitator the other as a scribe to provide support in the recording of ideas. The facilitator should ask each participant to introduce themselves briefly in a sentence or two. Ground-rules relating to confidentiality should be agreed. The facilitator should review the procedure for Nominal Group Technique and present the questions:

- *When might suspended visiting be acceptable to you i.e. in what circumstances would you be happy **not to be allowed to visit** someone in hospital or care home?*
- *When might suspended visiting **NOT** be acceptable to you i.e. in what circumstances would you NOT be happy **to be prevented from visiting** someone in hospital or care home?*
  *(you will be asked to think about issues such as perceived risk, severity of consequences, relationship between patient & visitor, information provision, distance visitor has travelled)*
- *What do you think the benefits of suspended visiting might be?*
- *What do you think the disadvantages of suspended visiting might be?(explore issues of distance travelled)*

The format of the Nominal Group Technique:
1. **Generation of ideas**. Individuals consider the first question and write down their ideas in a few words.
**2. Round robin recording of ideas**. Each group member presents, without discussion, one of the ideas on their list. The ideas are recorded by the scribe for everyone to see. The Facilitator then asks each person for a second idea, and so on, until all ideas are recorded. All ideas should be recorded as presented.
**3. Clarification of ideas.** At this stage anyone can seek clarification. If duplication has occurred then ideas may be combined with the agreement of the group. It is important to resist attempts to condense items into broader categories as the specificity of the original idea may be lost.
**4. Scoring.** Each member of the group has 10 points to be awarded. They may, for example, award 10 to the idea they believe is central, or allocate their marks across several of the responses. The total awarded by any individual should not exceed 10.
The facilitator will add the marks awarded
**5. Discussion** The results are then discussed in the group and recorded by the scribe, with the rank order of issues and concerns identified. The above process is repeated for the second question.